Annual Report to the General Assembly
Dental Care Access Under HealthChoice
November 2002

Background

The Maryland Medical Assistance program delivered oral health services to over 90,000 children and adult enrollees in CY 2001. These statistics mask problems in the delivery of oral health services to Medical Assistance enrollees. Maryland and many other states face numerous barriers in providing comprehensive oral health services to Medical Assistance enrollees including low provider participation, missed appointments, and low awareness among enrollees about the benefits of primary oral health care.

Senate Bill 590

Senate Bill 590 was passed during the 1998 legislative session and became effective on October 1, 1998. It established the Office of Oral Health and allowed DHMH to offer oral health services to pregnant women enrolled in managed care organizations (MCOs). It required the Department of Health and Mental Hygiene to establish a five-year oral health care plan that sets targets for enrollee access to oral health services for managed care organizations under the Maryland Medical Assistance program. The base for these targets is the rate of service use by children in 1997. In that year, 14 %[1] of Medical Assistance enrollees under 21 years of age used any oral health service. The target for the first year of the five-year plan, calendar year 2000, was 30%, with annual increases of 10% until a level of 70% is reached in 2004.

Senate Bill 590 also requires that DHMH submit an annual report addressing the following:

1. The availability and accessibility of dentists throughout the State participating in the Maryland Medical Assistance program;

2. The outcomes made by MCOs and dental managed care organizations in the Maryland Medical Assistance program in reaching the utilization targets required by Section 2 of the bill, including:

    a. Loss ratios that MCOs and dental managed care organizations experience in providing dental services;

    b. Corrective actions by MCOs and dental managed care organizations taken to achieve the utilization targets; and

3. The allocation and use of funds authorized by the bill.

[1] The 14% utilization is based on services provided to a child with any period of Medicaid eligibility. This statistic does not take into account any minimum enrollment period.

These topics are addressed in this report.

Availability and Accessibility of Oral Health Providers

HealthChoice MCOs are required to offer comprehensive oral health services including preventive care to children up to 21 years of age and to pregnant women. Adult services are optional, but all HealthChoice MCOs currently offer some oral health services to adults. MCOs are required to develop and maintain an adequate network of oral health providers who can deliver the full scope of oral health services. HealthChoice regulations (COMAR 10.09.66.05 and 10.09.66.06) specify the capacity and geographic standards for oral health providers. They require that the oral health provider to enrollee ratio be no higher than 1:2000 for each MCO. In addition, each MCO must ensure that enrollees have access to an oral health provider within a 30-minute or 10-mile radius for urban areas and a 30-minute or 30-mile radius for rural areas. MCOs must document compliance with these standards in their annual dental enhancement plans. Program staff review these plans and assess MCO progress via the MCO dental plans submitted annually. In addition, DHMH monitors the access standards via enrollee complaints.

As of July 2002, there were approximately 307 oral health providers enrolled as providers in the HealthChoice program. This represents an approximately 26% decrease in the number of oral health providers from last year. The decrease is mostly the result of an effort to clean up provider files and the provider directory during the last year. Some dentists that participate as providers through clinics are not included in Table 1 below, which therefore under-counts dentists in some regions such as the Eastern Shore. The overall statewide ratio of oral health providers to HealthChoice enrollees under age 20 was 1:1168 in June 2002, compared to 1:909 in June 2001, which is well within the COMAR-defined ratio of 1:2000.

Table 1: MCOs Dental Network Providers Listed in MCO Provider Directories (unduplicated count)

	July-01	July-02	% Change (01-02)	Counties
Baltimore Metropolitan Area	211	216	2%	Anne Arundel, Baltimore City, Baltimore County, Carroll, Harford, Howard
Montgomery/Prince George's	212	173	-18%	Montgomery, Prince George's
Southern Maryland	11	19	42%	Calvert, Charles, St. Mary's
Western Maryland	11	16	31%	Allegany, Garrett, Washington, Frederick
Eastern Shore	8	5**	-48%	Caroline, Cecil, Dorechester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, Worcester
Unduplicated Total*	365	307	-26%	24 Regions

*The unduplicated total is different than the total in each geographic region because it is possible for a dental provider to have multiple sites

**Does not include dentists that participate as providers through clinics, and therefore under-reports the number of dentists on the Eastern Shore

Source: HealthChoice Provider Listings

Table 1 illustrates the total number of providers as listed in the July 2002 HealthChoice Providers Listing published by the HealthChoice program. Some oral health providers may not be accepting new referrals and many limit the number of new referrals that they accept. Furthermore, these numbers only reflect the availability of general practitioners.

HealthChoice Dental Utilization Rates

Children

Dental care is a mandated health benefit for children through age 20 under EPSDT requirements. However, access to dental services for Maryland Medicaid children has been low for a number of years. In the last fee-for-service year, FY 1997, 14 percent of all children enrolled in Medicaid for any period of time received at least one dental service. This was well below the national average[2]. The General Assembly passed Senate Bill 590 that established targets for utilization of dental services for children enrolled in HealthChoice to reach 70 percent within five years, beginning with 30 percent in Year 1. By regulation, CY 2000 was established as Year 1 of the five-year Oral Health Plan developed by the Department. The Department has worked with the Oral Health Advisory Committee and the Managed Care Organizations to assess the HealthChoice program's progress in expanding access to dental services for children.

Program Performance

Since 1999, the Department annually produces information on children's access to dental services and reports this information to the MCOs and the Oral Health Advisory Committee. The Department uses the following criteria for assessing the HealthChoice program's performance in providing access to dental services for HealthChoice children:

1) the age range is from 3 through 20;
2) the child is enrolled in one MCO for a minimum of 90 days;
3) utilization consists of one or more dental services rendered during the year.

Using these measures, the overall percentage utilization across all HealthChoice MCOs increased by from 18.3% in FY 1997 to 26.7% in CY 2001, which is a 45.9% increase. Attachment 1 shows the age and regional breakdowns for these utilization statistics.

Table 2: Number of Children Receiving Dental Services
Children ages 3-20, enrolled for at least 90 days

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
FY 1997	151,360	27,712	18.3%
CY 1999	250,797	53,344	21.3%
CY 2000	277,635	67,585	24.3%

[2] Academy of Pediatrics State Medicaid Report for Federal FY 1996 - Analysis of HCFA National Data for Medicaid Children's Dental Services Utilization.

CY 2001	306,022	81,634	26.7%

MCO Plan Performance

In an effort to assess the performance of individual HealthChoice MCOs, the Department provides an additional analysis of the dental utilization data. This analysis uses a measure closely modeled on the National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS) measure for Medicaid children's dental services utilization. There are two primary differences between the plan performance services measure and the program performance criteria described above:

(1) the age range of children; and
(2) the minimum number of days of enrolled in a year.

The HEDIS methodology uses an age range from 4 through 21. The Department modified their age range to 4-20 years because the Maryland Medicaid program only requires dental coverage through age 20. HEDIS requires a minimum enrollment of 365 days with a gap of no more than 45 days during the year in one MCO, a 320-day measure. From FY 1997 there was an increase of 68.8% in access from 19.9% in FY 1997 to 33.6% in CY 2001. Attachment 2 shows the age and regional breakdowns for these utilization statistics.

Table 3: Number of Children Receiving Dental Services
Children ages 4-20, enrolled for at least 320 days

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
FY 1997	88,638	17,637	19.9%
CY 1999	122,756	31,742	25.9%
CY 2000	132,399	38,056	28.7%
CY 2001*	142,988	48,066	33.6%

*Starting with statistics provided in CY 2001, DHMH revised its methodology to include children enrolled in the same MCO for at least 320 days, consistent with HEDIS methodology. Prior to CY 2001, these data included individuals enrolled in any MCO for at least 320 days.

Type of Dental Services

Beginning in February 2002, the Department, working with the University of Maryland Dental School, began to look at the types of dental services that children receive. The analysis examined children's access to different types of services – diagnostic, preventive and restorative. The analysis addresses the concern that while access to dental care may have increased as is the case in the program or plan performance measures described above, the level of restorative services or treatment may not be adequate.

The findings indicate that access to both any dental service and access to restorative services has improved since 1997. Access to any dental service increased by 68.8% from 19.9% in FY 1997 to 33.6% in CY 2001 (Table 3) and access to restorative services increased by 63.6%

from 6.6% of all children receiving a restorative service in FY 1997 to 10.8% in CY 2001. The percentage of children receiving a restorative service remains below the anticipated need for low- income children[3] but is similar to the percentage of low-income children nationally that actually receive a restorative or other service.[4] The percentage of children who receive dental services who also receive a restorative service has remained fairly constant in CY 2001. These findings suggest that there have been improvements in both access to general dental services and also restorative care.

Table 4: Percentage of Children Receiving Dental Services by Type of Service
Children ages 4-20, enrolled for at least 320 days

Year	Diagnostic	Preventive	Restorative
FY 1997	19.6%	18.1%	6.6%
CY 2000	27.3%	24.6%	9.3%
CY 2001	31.7%	29.1%	10.8%

Pregnant Women

Senate Bill 590 also required that dental services be extended to include all pregnant women. The proportion of pregnant women 21 and over enrolled for at least 90 days receiving dental services was 15.4 percent in CY 2000 compared to 13.8 percent for CY 1999. In FY 1997, the comparable rate for pregnant women 21 and over receiving any dental services as reported in the fee-for-service system was less than 1 percent. Adult dental care was not covered by Medicaid. There is no HEDIS measure for dental services for pregnant women.

Table 5: All MCOs Dental Encounter Data for Pregnant Women 21+
enrolled for at least 90 days

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
FY 1997	17,323	96	0.6%
CY 1999	17,914	2,474	13.8%
CY 2000	18,514	2,843	15.4%
CY 2001	19,644	3,109	15.8%

All Adults

Neither Senate Bill 590 nor the HealthChoice program requires that adults other than pregnant women receive dental services. However, the managed care contract with the Department does provide that MCOs offering adult dental services would benefit through preferential assignment of auto-enrolled recipients. As a result, all MCOs offer adult dental benefits although these benefits are not uniform across MCOs. The recent analysis demonstrates

[3] Vargas, et al. "Oral Status of Preschool Children Attending HeadStart in Maryland, 2000" in Pediatric Dentistry, June 2002.
[4] Macek, et al. "An Analysis of Dental Visits in US Children, by Category of Service and Sociodemographic Factors, 1996," in Pediatric Dentistry, May 2001.

that 15% of adults, enrolled for at least 90 days received at least one dental service in Calendar 2001 compared to 14.9 percent in CY 2000 and less than 1% in FY 1997.

Table 6: Number of Adults 21+Receiving Dental Services enrolled for at least 90 days

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
FY 1997	221,371	375	0.2%
CY 1999	111,753	16,139	14.4%
CY 2000	114,223	16,986	14.9%
CY 2001	111,694	16,795	15.0%

Corrective Actions

DHMH monitors the number and percentage of oral health services provided by HealthChoice MCOs on a biannual basis using encounter data. DHMH will hold MCOs accountable for not meeting the dental utilization targets required for CY 2001 and CY 2002 through the use of sanctions.

HealthChoice regulations (COMAR 10.09.65.24) require the program's MCOs to submit Enhanced Dental Services Plans annually to the Department. These Plans contain new strategies that must: (1) assure adequate availability and accessibility by enrollees to network dentist; (2) address the MCOs' capability to meet the established yearly utilization targets; and (3) discuss their allocation and use of funds for oral health services.

On-Site Visits are annual face-to-face encounters between the Department's Medical Oral Health Team and the MCO's officials. The central items of discussion during these forums have been progress or lack of progress with existing strategies, necessity for developing and implementing new strategies and innovations. At a site visit, while considering the MCO and the Plan, Departmental staff may also suggest additional outreach strategies or practices that have been known to be successful for other MCOs. Some of the successful strategies include:

Enrollee Strategies

- The development of a Member Incentive Program designed to induce members to seek oral health care;

- The HeadStart and Homework Program Directors to educate parents and their children on the benefits and importance of regular dental visits;

- MCOs' customer service representatives ask each member about their oral health during routine telephone communications, and then coordinate the scheduling of dental appointments for interested members; and

- The simultaneous scheduling of medical and dental appointments.

Provider Strategies

- In an effort to establish face-to-face contact with essential providers and induce their participation, MCO representatives will attend a meeting of the Pediatric Oral Health Group.

Allocation of Funds

Dental funding has increased significantly, from $5.3 million in FY 1999 to $33 million in CY 2003, with a potential supplemental funding amount of $8.5 million. This increase reflects increases in the Medical Assistance fee schedule for dental services and increased utilization under HealthChoice.

In fall 2002, DHMH changed the MCO capitation rate setting methodology for dental services rendered in CY 2003. This new methodology prospectively pays MCOs for dental utilization of 40% and allow MCOs to draw funds down for utilization beyond 40%. Prior to CY 2003 rates, MCOs rates were established based on the utilization targets in Senate Bill 590. However, based on current encounter data, MCOs are not likely to meet these high standards. Therefore, a more realistic target of 40% was used in developing rates, but a supplemental pool is available if MCOs are able to demonstrate that they exceed the 40% utilization target.

ATTACHMENT 1

Dental Utilization Rates, FY 1997, CY 2000 and CY 2001
Enrollment ≥ 90 days in an MCO, age 3-20

Criteria	FY 1997	CY 2000	CY 2001
Age			
3	11.7%	16.4%	18.8%
4-5	19.3%	24.8%	27.7%
6-9	21.4%	27.8%	30.8%
10-14	20.6%	26.1%	28.4%
15-18	16.5%	21.6%	23.5%
19-20	9.1%	14.6%	15.9%
All 3-20	18.3%	24.3%	26.7%
Region			
Baltimore City	21.3%	21.8%	24.0%
Baltimore Suburbs	18.4%	26.2%	27.7%
Washington Suburbs	15.0%	24.1%	27.7%
Western Maryland	24.1%	32.7%	37.6%
Southern Maryland	15.9%	22.0%	23.6%
Eastern Shore	13.5%	26.6%	25.4%

ATTACHMENT 2

Dental Utilization Rates, FY 1997, CY 2000 and CY 2001
Enrollment ≥ 320 days in an MCO, age 4-20

Criteria	FY 1997	CY 2000	CY 2001
Age			
4-5	20.7%	29.3%	33.3%
6-9	23.1%	31.6%	37.2%
10-14	21.6%	29.2%	34.1%
15-18	16.6%	24.7%	29.4%
19-20	8.3%	17.8%	19.7%
All 4-20	19.9%	28.7%	33.6%
Region			
Baltimore City	20.2%	25.1%	27.4%
Baltimore Suburbs	22.8%	32.5%	35.4%
Washington Suburbs	19.2%	30.4%	35.9%
Western Maryland	29.2%	38.2%	46.0%
Southern Maryland	14.6%	26.5%	29.3%
Eastern Shore	9.2%	26.4%	32.6%